No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent,

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF RIGHT TO LIFE LEAGUE OF SOUTHERN CALIFORNIA, INC. AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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EDITOR'S NOTE:

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of the parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

The Right to Life League of Southern California, Inc, is perhaps the largest and oldest non religious C3 pro life group. It opposes abortion and euthanasia.

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SUMMARY OF ARGUMENT

Euthanasia was a popular American and British concept in the 1930's. Warnings derived from the War Crimes Trials and the Nazi experience then killed the concept until the late 1950's. In 1958, law professor Yale Kamisar responded to "The Sanctity of Human Life and the Criminal Law" by Glanville Williams by publishing "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation" [Minn L Rev 42:969-1042(May) 1958. With slight change, the portions of the article listed in the table of contents are reproduced herein.

It is argued that there is too great a risk of error. There are unsolvable dilemmas relating to how the right to euthanasia might be worded by law or Court decision. In balance, the sacrifice of some who should not die plus some who

would wrongly be coerced into dying (very gently and perhaps from good motives in many cases once euthanasia became thinkable) far outweighs the detriment from the lingering of some having no desire or reason to linger. Radiations from a euthanasia law and problems relating to choice will be unsolvable. Any reversal herein will do much damage by adding a choice to the care of the elderly they presently do not consider, the choice of being killed to save everyone else a lot of expense and trouble. Better the present law which is probably not much if any worse than the rest of the criminal law, than any euthanasia alternative yet suggested. The present law is very flexible in its application to euthanasia type cases and is a good compromise of the conflicting interests. Footnotes have been omitted.

The Law On The Books condemns all "mercy killings", even those caused by starvation of the PVS. That this has a substantial deterrent effect, even its harshest critics admit. Of course, it does not stamp out all "mercy killings," just as murder and rape provisions do not stamp out all murder and rape, but presumably it does impose a substantially greater responsibility on physicians and relatives in a euthanasia situation and turns them away from significantly more doubtful cases than would otherwise be the practice under any proposed euthanasia legislation to date. When a "mercy killing" occurs, however, The Law In Action is as malleable as The Law On The Books is uncompromising. The high incidence of failures to indict, acquittals, suspended sentences and

reprieves lend considerable support to the view that if the circumstances are so compelling that the defendant ought to violate the law, then they are compelling enough for the jury to violate their oaths. The law does well to declare these homicides unlawful. It does equally well to put no more than the sanction of an oath in the way of an acquittal.

The complaint has been registered that "the prospect of a sentimental acquittal cannot be reckoned as a certainty." Of course not. The defendant is not always entitled to a sentimental acquittal. The few American convictions cited for the proposition that the present state of affairs breeds "inequality" in application may be cited as well for the proposition that it is characterized by elasticity, flexibility. In any event, if inequality of

application suffices to damn a particular provision of the criminal law, we might as well tear up all our codes-beginning with the section on chicken-stealing.

The criticism is also made that public confidence in the administration of criminal justice is hardly strengthened when moral issues are shifted instead of being solved, or when the law relegates to juries the function of correcting its inequities.

But there are many, many occasions on which the jury wrestles with moral issues, and there is certainly substantial support for this practice.

The existing law on euthanasia is hardly perfect. But if it is not too good, neither, as I have suggested, is it much worse than the rest of the criminal law. At any rate, the imperfections of the existing law are not cured by

Williams' proposal. Indeed, I believe adoption of his views would add more difficulties than it would remove.

Williams strongly suggests that "euthanasia can be condemned only according to a religious opinion. He tends to view the opposing camps as Roman Catholics versus Liberals. Although this has a certain initial appeal to me, a non-Catholic and a self-styled liberal, I deny that this is the only way the battle-lines can, or should, be drawn. I leave the religious arguments to the theologians. I share the view that "those who hold the faith may follow its precepts without requiring those who do not hold it to act as if they did." But I do find substantial utilitarian obstacles on the high road to euthanasia.

As an ultimate philosophical proposition, the case for voluntary

euthanasia is strong. Whatever may be said for and against suicide generally, the appeal of death is immeasurably greater when it is sought not for a poor reason or just any reason, but for "good cause," so to speak; when it is invoked not on behalf of a "socially useful" person, but on behalf of, for example, the pain-racked "hopelessly incurable" cancer victim. If a person is in fact (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die, I would hate to have to argue that the hand of death should be stayed. But abstract propositions and carefully formed hypotheticals are one thing; specific proposals designed to cover every day situations are something else.

In essence, Williams' specific proposal is that death be authorized for a person in the above situation "by giving the medical practitioner a wide discretion and trusting to his good sense." This, I submit, raises too great a risk of abuse and mistake to warrant a change in the existing law. That a proposal entails risk of mistake is hardly a conclusive reason against it. But neither is it irrelevant. Under any euthanasia program the consequences of mistake, of course, are always fatal. As I shall endeavor to show, the incidence of mistake of one kind or another is likely to be quite appreciable. If this indeed be the case, unless the need for the authorized conduct is compelling enough to override it, I take it the risk of mistake is a conclusive reason against such authorization. I submit, too, that

the possible radiations from the proposed legislation, e.g., involuntary euthanasia of idiots and imbeciles (the typical "mercy killings" reported by the press) and the emergence of the legal precedent that there are lives not "worth living," give additional cause to pause.

I see the issue, then, as the need for voluntary euthanasia versus (1) the incidence of mistake and abuse; (2) the danger that legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others.

The "freedom to choose a merciful death by euthanasia may well be regarded, as "a special area of civil liberties far removed from the familiar concerns with criminal procedures, race discrimination and freedom of speech and religion." The civil liberties angle is definitely a

part of Professor Williams' approach:

"If the law were to remove its ban on euthanasia, the effect would merely be to leave this subject to the individual conscience. This proposal would...be easy to defend, as restoring personal liberty in a field in which men differ on the question of conscience..."

On a question like this there is surely everything to be said for the liberty of the individual.

I am perfectly willing to accept civil liberties as the battlefield, but issues of "liberty" and "freedom" mean little until we begin to pin down whose "liberty" and "freedom" and for what need and at what price. This paper is concerned largely with such questions.

It is true also of journeys in the law that the place you reach depends on the direction you are taking. And so,

where one comes out on a case depends on where one goes in.

So it is with the question at hand. Williams champions the "personal liberty" of the dying to die painlessly. I am more concerned about the life and liberty of those who would needlessly be killed in the process or who would irrationally choose to partake of the process. Williams' price on behalf of those who are in fact "hopeless incurables" and in fact of a fixed and rational desire to die is the sacrifice of (1) some few, who, though they know it not, because their physicians know it not, need not and should not die; (2) others, probably not so few, who, though they go through the motions of "volunteering," [or like Cruzan, are volunteered,] are casualties of strain, pain or narcotics to such an extent that they really know not what

they do. My price on behalf of those who, despite appearances to the contrary, have some relatively normal and reasonably useful life left in them, or who are incapable of making the choice, is the lingering on for a while of those who, if you will, in fact have no desire and no reason to linger on.

I. A CLOSE-UP VIEW OF VOLUNTARY EUTHANASIA

A. The Euthanasiast's Dilemma and Williams' Proposed Solution

As if the general principle they advocate did not raise enough difficulties in itself, euthanasiasts have learned only too bitterly that specific plans of enforcement are often much less palatable than the abstract notions they are designed to effectuate.

In the case of voluntary euthanasia, the means of implementation vary from (1)

the simple proposal that "mercy killings" by anyone, typically relatives, be immunized from the criminal law; to (2) the elaborate legal machinery contained in the bills of the Voluntary Euthanasia Legalization Society (England) and the Euthanasia Society of American for carrying out euthanasia.

The English Society would require the eligible patient, i.e., one over twenty-one and "suffering from a disease involving severe pain and of an incurable and fatal character," to forward a specially prescribed application-along with two medical certificates, one signed by the attending physician, and the other by a specially qualified physician-to a specially appointed Euthanasia Referee "who shall satisfy himself by means of a personal interview with the patient and other wise that the said conditions shall

have been fulfilled and that the patient fully understands the nature and purpose of the application"; and, if so satisfied, shall then send a euthanasia permit to the patient; which permit shall, seven days after receipt, become "operative" in the presence of an official witness; unless the nearest relative manages to cancel the permit by persuading a court of appropriate jurisdiction that the requisite conditions have not been met.

The American Society would have the eligible patient, i.e.,one over twenty-one "suffering from severe physical pain caused by a disease for which no remedy affording lasting relief or recovery is at the time known to medical science," petition for euthanasia in the presence of two witnesses and file same, along with the certificate of an

attending physician, in a court or appropriate jurisdiction; said court to then appoint a committee of three, of whom at least two must be physicians, "who shall forthwith examine the patient and such other persons as they deem advisable or as the court may direct and within five days after their appointment, shall report to the court whether or not the patient understands the nature and purpose of the petition and comes within the [act's] provisions"; whereupon, if the report is in the affirmative, the court shall-"unless there is some reason to believe that the report is erroneous or untrue" grant the petition: in which event euthanasia is to be administered in the presence of the committee, or any two members thereof.

As will be seen, and as might be expected, the simple negative proposal to

remove "mercy killings" from the ban of the criminal law is strenuously resisted on the ground that it offers the patient far too little protection from not-so-merciful killings. On the other hand, the elaborate affirmative proposals of the euthanasia societies meet much pronounced eye blinking, not a few guffaws, and sharp criticism that the legal machinery is so drawn-out, so complex, so formal and so tedious as to offer the patient far too little solace.

The naked suggestion that "mercy killing" be made a good defense against a charge of criminal homicide appears to have no prospect of success in the foreseeable future. Only recently, the Royal Commission on Capital Punishment "reluctantly" concluded that such homicides could not feasibly be taken out of the category of murder, let alone

completely immunized:

> [Witnesses] thought it would be most dangerous to provide that "mercy killings" should not be murder, because it would be impossible to define a category which could not be seriously abused. Such a definition could only be in terms of the motive of the offender... which is notoriously difficult to establish and cannot, like intent, be inferred from a person's overt actions. Moreover it was agreed by almost all witnesses, including those who thought that there would be no real difficulty in discriminating between genuine and spurious suicide pacts, that, even if such a definition could be devised, it would in practice often prove extremely difficult to distinguish killings where the motive was merciful from those where it was not. How, for

example, were the jury to decide whether a daughter had killed her invalid father from compassion, from a desire for material gain, from a natural wish to bring to an end a trying period of her life, or from a combination of motives?

While the appeal in simply taking "mercy killings" off the books is dulled by the likelihood of abuse, the force of the idea is likewise substantially diminished by the encumbering protective features proposed by the American and English Societies. Thus, Lord Dawson, an eminent medical member of the House of Lords and one of the great leaders of the English medical profession, protested that the English Bill "would turn the sick room into a bureau," that he was revolted by "the very idea of the sick chamber being visited by officials and the patient, who is struggling with this

dire malady, being treated as if it was a case of insanity.: Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, reflected that the proposed machinery would "produce an atmosphere quite foreign to all accepted notions of dying in peace." Dr. I. Phillips Frohman has similarly objected to the American Bill as one whose whole procedure is so lengthy that it does not seem consonant either with the mercy motive on which presumably it is based, or with the bearableness of the pain.

The extensive procedural concern of the euthanasia bills have repelled many, but perhaps the best evidence of its psychological misconception is that it has distressed sympathizers as well. The very year the English Society was organized and a proposed bill drafted, Dr. Harry Roberts observed: "We all

realize the intensified horror attached to the death penalty by its accompanying formalities-from the phraseology of the judge's sentence, and his black cap, to the weight-gauging visit of the hangman to the cell, and the correct attendance at the final scene of the surpliced chaplain, the doctor, and the prison governor. This is not irrelevant to the problem of legalized euthanasia..."

After discussing the way procedural steps of the English bill Dr. Roberts observed: "I can almost hear the cheerful announcement: "please,ma'am, the euthanizer's come."

At a meeting of the Medico-Legal Society, Dr. Kenneth McFadyean, after reminding the group that some time ago he stated from public platform that he had practiced euthanasia for twenty years and he did not believe he was running risks

because he had helped a hopeless sufferer out of this life, commented:

"There was no comparison between being in a position to make a will and making a patient choose his own death at any stated moment. The patient had to discuss it-not once with his own doctor, but two, three, or even four times with strangers, which was no solace or comfort to people suffering intolerable pain.

Nothing rouses Professor Williams' ire more than the fact that opponents of the euthanasia movement argue that euthanasia proposals offer either inadequate protection or over elaborate safeguards. Williams appears to meet this dilemma with the insinuation that because arguments are made in the antithesis they must each be invalid, each be obstructionist, and be made in bad faith.

It just may be, however, that each

alternative argument is quite valid, that the trouble lies with the euthanasiasts themselves in seeking a goal which is inherently inconsistent: a procedure for death which both (1) provides ample safeguards against abuse and mistake; and (2) is "quick" and "easy" in operation. Professor Williams meets the problem with more than bitter comments about the tactics of the opposition. He makes a brave try to break through the dilemma:

"The reformers might be well advised, in their next proposal, to abandon all their cumbrous safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.

The essence of the bill would then be simple. It would provide that no medical practitioner should be guilty of an offense in respect of an act done

intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.

Evidently the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about

current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not the general practitioner will accept a responsibility Williams would confer on him is itself a problem of major proportions. Putting that question aside, the soundness of the underlying premises of Williams' "legislative suggestion will be examined in the course of the discussion of various aspects of the problem.

B. "The Choice"

Under current proposals to establish legal machinery, elaborate or otherwise, for the administration of a quick and easy death, it is not enough that those authorized to pass on the question decide that the patient, in effect, is "better off dead." The patient must concur in this opinion. Much of the appeal in the

current proposal lies in this so-called "voluntary" attribute.

But is the adult patient really in a position to concur? Is he truly able to make euthanasia a voluntary" act? There is a good deal to be said, is there not, for Dr. Frohman's pithy comment that the "voluntary" plan is supposed to be carried out "only if the victim is both sane and crazed by pain."

By hypothesis, voluntary euthanasia is not to be resorted to until narcotics have long since been administered and the patient has developed a tolerance to them. When, then, does the patient make the choice? While heavily drugged? Or is narcotic relief to be withdrawn for the time of decision? But if heavy dosage no longer deadens pain, indeed, no longer makes it bearable, how overwhelming is it when whatever relief narcotics offer is

take away, too?

Hypersensitivity to pain after analgesia has worn off is nearly always noted. Moreover, ...the mental side-effects of narcotic, unfortunately for any one wishing to suspend them temporarily without unduly tormenting the patient, appear to outlast the analgesic effect and by many hours.

The situation is further complicated by the fact that a person in terminal stages of cancer who had been given morphine steadily for a matter of weeks would certainly be dependent upon it physically and would probably be addicted to it & react with the addict's response.

The narcotics problem aside, Dr. Benjamin Miller, who probably has personally experienced more pain than any other commentator on the euthanasia scene, observes:

"Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought."

If, say, a man in this plight were a criminal defendant and he were to decline the assistance of counsel would the courts hold he had "intelligently and understandingly waived counsel?

Undoubtedly, some euthanasia candidates will have their lucid moments. How they are to be distinguished from fellow sufferers who do not, or how these instances are to distinguished from others when the patient is exercising an irrational judgement is not an easy matter. Particularly is this so under Williams' proposal, where no specially

qualified persons, psychiatrically trained or otherwise, are to assist in the process.

Assuming, for purposes of argument, that the occasion when a euthanasia candidate possesses a sufficiently clear mind can be ascertained and that a request for euthanasia is then made, there remain other problems. The mind of the pain racked may occasionally be clear, but is it not also likely to be uncertain and variable? This point was pressed hard by the great physician, Lord Horder, in the House of Lords debates:

"During the morning depression he [the patient] will be found to favour the application under this Bill, later in the day he will think quite differently, or will have forgotten all about it. The mental clarity with which noble Lords who present this Bill are able to think and

to speak must not be thought to have any counterpart in the alternating moods and confused judgments of the sick man."

The concept of "voluntary" in voluntary euthanasia would have a great deal more substance to it if, as is the case with voluntary admission statutes for the mentally ill, the patient retained the right to reverse the process within a specified number of days after he gives written notice of his desire to do so-but unfortunately this cannot be. The choice is an irrevocable one.

The likelihood of confusion, distortion or vacillation would appear to be serious drawbacks to any voluntary plan. Moreover, Williams' proposal is particularly vulnerable in this regard, since, as he admits, by eliminating the fairly elaborate procedure of the American and English Societies' plans, he

also eliminates a time period which would furnish substantial evidence of the patient's settled intention to avail himself of euthanasia. But if Williams does not always choose to slug it out, he can box neatly and parry gingerly:

"The problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a law if it has a beneficial operation. The measure here proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible. The physician, conscious of the need to protect himself against malicious accusations, can devise his own safeguards appropriate to the circumstance: he would normally be well advised to get the patient's consent in writing, just as is now the practice

before operations. Sometimes the patient's consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed and before he comes to be racked by pain; if the expression of desire is never revoked, but rather is reaffirmed under the pain, there is the best possible proof of full consent. If, on the other hand, there is no such settled frame of mind, & if the physician chooses to administer euthanasia when the patient's mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected."

If consent is given at a time when the patient's condition has so degenerated that he has become a fit candidate for euthanasia, when, if ever, will it be "clear and incontrovertible?" Is the suggested alternative of consent

in advance a satisfactory solution? Can such a consent be deemed an informed one? Is this much different from holding a man to a prior statement of intent that if such and such an employment opportunity would present itself he would accept it, or if such and such a young woman were to come along he would marry her? Need one marshal authority for the proposition that many an "iffy" inclination is changed when actual facts are at hand?

Professor Williams states that where a pre-pain desire for "ultimate euthanasia" is "reaffirmed" under pain, "there is the best possible proof of full consent." Perhaps. But what if it is alternately renounced and reaffirmed under pain? What if it is neither affirmed or renounced? What if it is only renounced? Will a physician be free to go ahead on the ground that the prior desire

was "rational," but the present desire "irrational? Under Williams' plan, will not the physician frequently "be walking in the margin of the law"-just as he is now? Do we really accomplish much more under this proposal than to put the euthanasia principle on the books?

Even if a patient's choice could be said to be "clear and incontrovertible: do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some

feel an obligation to have themselves "eliminated" in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

It would not be surprising for the gravely ill person to seek to inquire of those close to him whether he should avail himself of the legal alternative of euthanasia. Certainly, he is likely to wonder about their attitude in the matter. It is quite possible, is it not, that he will not exactly be gratified by any inclination on their part-however noble their motives may be in fact-that he resort to the new procedure? At this stage, the patient-family relationship may well be a good deal less than it ought to be. Illness, pain and fear of

death tend to activate the dependent longings for the family. Conflict can easily arise, since it may be very difficult for the individual to satisfy his need for these passive dependent needs and his previous concept of the necessity for competitive, constructive individuality. Our culture provides few defenses for this type of stress beyond a suppression of the need. If his defenses break down, he may feel angry toward himself and toward his family.

And what of the relatives? If their views will not always influence the patient, will they not at least influence the attending physician? Will a physician assume the risks to his reputation, if not his pocketbook, by administering the coup de grace over the objection-however irrational-of a close relative? Do not the relatives, then, also have a

"choice"? Is not the decision on their part to do nothing and say nothing itself "choice"? In many families there will be some, will there not, who will consider a stand against euthanasia the only proof of love, devotion and gratitude for past events? What of the stress and strife if close relatives differ-as they did in the famous Sander Case-over the desirability of euthanatizing the patient?

At such a time, as the well-known Paight case clearly demonstrates, members of the family are not likely to be in the best state of mind, either, to make this kind of decision, financial stress and conscious or unconscious competition for the family's estate aside.

The chronic illness and persistent pain in terminal carcinoma may place strong and excessive stresses upon the family's emotional ties with the patient.

The family members who have strong emotional attachment to start with are most likely to take the patient's fears, pains and fate personally. Panic often strides them. Whatever guilt feelings they may have toward the patient emerge.

If the patient is maintained at home, many frustrations and physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence and bad odors. The pressure of caring for the individual under these circumstances is likely to arouse a resentment and, in turn, guilt feelings on the part of those who have to do the nursing.

Nor should it be overlooked that while Professor Williams would remove the various procedural steps and the various personnel contemplated in the American and English Bills and bank his all on the

"good sense" of the general practitioner, no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient, not even the general practitioner:

Working with a patient suffering from a malignancy causes special problems for the physician. First of all, the patient with a malignancy is most likely to engender anxiety concerning death, even in the doctor. And at the same time, this type of patient constitutes a serious threat or frustration to medical ambition. As a result, a doctor may react more emotionally and less objectively than in any other area of medical practice. His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He

may even feel almost inclined to want to avoid this type of patient.

The only Anglo-American prosecution involving an alleged "mercy killing" physician seems to be the case of Dr. Herman Sander. The state's testimony was to the effect that, as Sander had admitted on various occasions, he finally yielded to the persistent pleas of his patients's husband and pumped air into her veins "in a weak moment." Sander's version was that he finally "snapped" under the strain of caring for the cancer victim, bungled simple tasks, and became "obsessed" with the need to "do something" for her-if only to inject air into her already dead body. Whichever side one believes-and the jury evidently believed Dr. Sander- the case well demonstrates that at the moment of decision the tired practitioner's "good

sense" may not be as good as it might be.

Putting aside the problem of whether the good sense of the physician warrants dispensing with other personnel, there still remains the problems posed by any voluntary euthanasia program: the aforementioned considerable pressures on the patient and his family. Are these the kinds of pressures we want to impose on any family, let alone an emotionally battered family? And if so, why are they not also proper considerations for the crippled, the paralyzed, the quadruple amputee, [the PVS] and their families?

Might it not be said of the existing ban on euthanasia, as Professor Herbert Wechsler has said of the criminal law in another connection:

"It also operates, and perhaps more significantly, at anterior stages in the patterns of conduct, the dark shadow of

organized disapproval eliminating from the ambit of consideration alternatives that might otherwise present themselves in the final competition of choice.

C. The "Hopelessly Incurable" Patient and The Fallible Doctor

Professor Williams notes as "standard argument" the plea that

"...no sufferer from an apparently fatal illness should be deprived of his life because there is always the possibility that the diagnosis is wrong, or else that some remarkable cure will be discovered in time."

But he does not reach the issue until he has already dismissed it with this prefatory remark:

"It has been noticed before in this work that writers who object to a practice for theological reasons frequently try to support their

condemnation on medical grounds. With euthanasia this is difficult, but the effort is made.

Does not Williams, while he pleads that euthanasia not be theologically prejudged, at the same time invite the inference that nontheological objections to euthanasia are simply camouflage?

It is no doubt true that many theological opponents employ medical arguments as well, but it is also true that the doctor who has probably most forcefully advanced medical objections to euthanasia of the so-called incurables, Cornell University's world-renowned Foster Kennedy, a former president of the Euthanasia Society of America, advocates euthanasia in other areas where error in diagnosis and prospect of new relief or cures are much reduced, i.e., the "congenitally unfit." In large part for

the same reasons, Great Britain's Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, maintained that a better case could be made for the destruction of congenital idiots and those in the final stages of dementia, particularly senile dementia, than could be made for the doing away of the pain-stricken incurable. Surely, such opponents of voluntary euthanasia cannot be accused of wrapping theological objections in medical dressing!

Until the euthanasia societies of England and America had been organized and a party decision reached, shall we say, to advocate euthanasia only for incurables on their request, Dr. Abraham L. Wolbarst, one of the most ardent supporters of the movement, was less troubled about putting away "insane or defective people [who] have suffered

mental incapacity and tortures of the mind for many years" than he was about the "incurables." He recognized the "difficulty involved in the decision as to incurability" as one of the "doubtful aspects of euthanasia."

Doctors are only human beings, with few if any supermen among them. They make honest mistakes, like other men, because of the limitations of the human mind.

He noted further that "...it goes without saying that, in recently developed cases with a possibility of cure, euthanasia should not even be considered, the law might establish a limit of, say, ten years in which there is a chance of the patient's recovery."

Dr. Benjamin Miller is another who is unlikely to harbor an ulterior theological motive. His interest is more personal. He himself was left to die the

death of a "hopeless" tuberculosis victim only to discover that he was suffering from a rare malady which affects the lungs in much the same manner but seldom kills. Five years and sixteen hospitalizations later, Dr. Miller dramatized his point by recalling the last diagnostic clinic of the brilliant Richard Cabot, on the occasion of his official retirement:

He was given the case records [complete medical histories and results of careful examination] of two patients and asked to diagnose their illnesses... The patients had died and only the hospital pathologist knew the exact diagnosis, for he had seen the descriptions of the postmortem findings. Dr. Cabot, usually very accurate in his diagnosis, that day missed both.

The chief pathologist who had

selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.

Richard Cabot was brilliant. When one reads the account of his last clinic, one cannot help but think of how fallible the average general practitioner must be, how fallible the young doctor just starting practice must be-and this, of course, is all that some small towns have in the way of medical care-how fallible the worst practitioner, young or old, must be. If the range of skill and judgement among licensed physicians approaches the wide gap between the very best and the very worst members of the bar-and I have no reason to think it does

not-then the minimally competent physician is hardly the man to be given the responsibility for ending another's life. Yet, under Williams' proposal the marginal physician, as well as his more distinguished brethren, would have legal authorization to make these decisions. Euthanatizing a patient or two would all be a part of the routine day's work.

Perhaps it is not amiss to add as final note, that no less a euthanasiast than Dr. C. Killick Millard had such little faith in the average general practitioner that as regard the mere administering of the coup de grace, he observed: "In order to prevent any likelihood of bungling, it would be very necessary that only medical practitioners who had been specially licensed to euthanise (after acquiring special knowledge and skill) should be allowed to

administer euthanasia. Quite possibly, the work would largely be left in the hands of official euthanisors, who would have to have to be appointed specially for each area."

True, the percentage of correct diagnosis is particularly high in cancer. The short answer, however, is that euthanasiasts most emphatically do not propose to restrict "mercy killing to cancer cases. Dr. Millard has maintained that there are very many diseases besides cancer which tend to kill "by inches," and where death, when it does at last come to the rescue, is brought about by pain and exhaustion. Furthermore, even if mercy killings were to be limited to cancer, however relatively accurate the diagnosis in these cases here, too, incurability of a disease is never more than an estimate based upon experience,

and how fallacious experience may be in medicine only those who have had great deal of experience fully realize.

Dr. Daniel Laszlo, Chief of Division of Neoplastic Diseases, Montefiore Hospital, New York City, and three other physicians have observed:

" The mass crowding of a group of patients labled "terminal" in institutions designated for that kind of care carries a grave danger. The experience gathered from this group makes it seem reasonable to conclude that a fresh evaluation of any large group in mental institutions, in institutions for chronic care, or in homes for the incurably sick, would unearth a rewarding number of salvageable patients who can be returned to their normal place in society...For purposes of this study we were especially interested those with a

diagnosis of advanced cancer. In a number other patients major errors in diagnosis or management were encountered."

The authors then discuss in considerable detail the case histories of eleven patients admitted or transferred to Montefiore Hospital with the diagnosis of "advanced cancer in its terminal stage, "none of whom had cancer at all." In three cases the organ suspected to be the primary site of malignancy was unaffected; in the other eight cases it was the site of some nonmalignant disease. the impact of the findings may be gleaned from a subsequent comment by Doctor Laszlo and Spencer:

"Such cases [of mistaken diagnosis of advanced cancer] are encountered even in large medical centers and probably many more could be found in ~~areas~~ poorly provided with medical facilities."

Only recently, Dr. R. Ger, citing case histories of false cancer diagnoses to buttress his point, had occasion to warn his colleagues: "Students are often told, and one is exhorted repeatedly in textbooks to do so, to regard signs and symptoms appearing over the age of 40 years as due to carcinoma [malignant epithelial tumor] until proved otherwise. While it is true that carcinoma should take first place on grounds of commonness, it must not be forgotten that there are other conditions which may mimic carcinoma clinically radiologically and at operation, and which are essentially benign. There is danger, moreover, when presented with a case simulating carcinoma to assume it to be carcinoma without proving or disproving the diagnosis. This may give rise to unnecessary fatalities by either denying

treatment because of a hopeless prognosis or carrying out unnecessary procedures."

Even more recently, Doctors De Vet and Walder scored the "extremely dangerous" tendency on the part of general practitioners and specialists alike "...when a neoplasm becomes manifest in a patient previously operated on for a malignant tumour...to presume that the new growth is a metastasis [a transfer of the malignant disease.]."

Their studies demonstrated that it is "by no means a rare occurrence" for patients to develop "another, benign tumour after having been operated upon for a malignant one." De Vet and Walder also stress the "remarkable similarity" in symptoms, including "violent pain" in both cases, between metastases and benign processes of the spinal column and the spinal cord.

Faulty diagnosis is only one ground for error. Even if the diagnosis is correct, a second ground for error lies in the possibility that some measure of relief, if not a full cure, may come to the fore within the life expectancy of a patient. One pro euthanasia answer is: "It must be little comfort to a man slowly coming apart from multiple sclerosis to think that 15 years from now, death might not be his only hope."

To state the problem this way is, of course, to avoid it entirely. How do we know that fifteen days or fifteen hours from now, "death might not be the incurable's only hope."?

Another answer is that no cure for cancer which might be found "tomorrow " would be of any value to a man or woman "so far advanced in cancerous toxemia as to be an applicant for euthanasia.

As I shall endeavor to show, this approach is a good deal easier to formulate than it is to apply. For one thing, it presumes that we know today what cures will be found tomorrow. For another, it overlooks that if such cases can be said to exist, the patient is likely to be so far advanced in cancerous toxemia as to be no longer capable of understanding the step he is taking and hence beyond the stage when euthanasia ought to be administered.

A generation ago, Dr. Haven Emerson, then President of the American Public Health Association, made the point that

"...no one can say today what will be incurable tomorrow. No one can predict what disease will be fatal or permanently incurable until medicine becomes stationary and sterile." Dr. Emerson went so far as to say that "to be at all

accurate we must drop altogether the term "incurables" and substitute for it some such term as "chronic illness."

That was a generation ago. Dr. Emerson did not have to go far to document his contention. Before Banting and Best's insulin discovery, many a diabetic had been doomed. Before Whipple-Minot-Murphy liver treatment made it a relatively minor malady, many a pernicious anemia sufferer had been branded "hopeless." Before the uses of sulfanilimide were disclosed, a patient with widespread streptococcal blood poisoning was a condemned man.

Today, we may take even that most resolute disease, cancer, and we need look back no further than the last decade or more of research in this field to document the same contention.

In 1950, Dr William McCarthy began an

effort to open a new approach to cancer treatment of patients in advanced or terminal phases of disease.

Dr. McCarthy summarizes the results:

"In several of these cases there was associated tumor regression or arrest, with definite prolongation of life in increased comfort. This group constituted 15 percent of the series. Reserved for the classification as excellent response were 16 additional patients (16 percent whose subjective and objective remissions were striking, often accompanied with tumor regression or arrest, and whose improvement persisted for six months or longer. These patients represent the true temporary remissions of the series. They are, however, temporary remissions and not permanent remissions or so-called "cures." Nevertheless, as a group originally considered hopeless, each has

been afforded longer life, acceptable health and freedom from pain. Fortunately, prolongation of life appeared to occur only in patients who received good palliation.... Unusual temporary remissions for intervals as long as three years were obtained..."

Needless to say, a number of those who received substantial benefits from this particular therapy were suffering from great pain and appeared to be leading candidates for voluntary euthanasia. In 1950, the year the new combination therapy investigation was initiated, a swift death appeared to be their only hope. Instead they resumed full and useful lives for a considerable period of time.

Since February, 1951, in a new effort to inhibit certain cancer growth, a number of advanced cancer patients at

the Memorial Center for Cancer and Allied Disease have had their adrenal glands removed. Of a total of ten patients with cancer of the prostate adrenalectomized at the time of the 1952 report, three died in the immediate postoperative period of various cause, leaving seven effective cases for evaluation:

"The most striking beneficial response to adrenalectomy was relief of pain. Three of the patients were confined to bed with pain prior to surgery and were taking narcotics frequently...All three had striking relief of pain postoperatively and became ambulatory. One (L.W.) was in a stuporous condition preoperatively, confined to bed, and unable to feed himself. Following adrenalectomy his general condition improved remarkably. He became ambulatory and was able to return home to live a

relatively normal life. This improvement has been maintained until the present, 218 days after surgery...

Summarizing the prostatic cancer cases, all seven effective cases had striking subjective improvement. Only two cases showed objective improvement was temporary in all cases."

From all indications "J.W." was a most attractive target for the euthanasiasts. He was suffering from

"...severe pain requiring frequent injections of narcotics for relief...was extremely lethargic and relatively unresponsive...had to be fed by the nursing staff."

If he, to use Dr. Wolbarst's words, was not "so far advanced in cancerous toxemia as to be an applicant for euthanasia," when will anybody be? I am not at all sure that at this point J.W.

was still capable of consenting to his death. If he were, he certainly had reached the very brink. As it turned out, however, to have put J.W. out of his misery at the time would have been to deprive him of over seven months of a "relatively normal Life." Adequate quantities of cortisone and other active corticoids had just become available. The postoperative problem of adrenal insufficiency had just been solved.

Breast cancer, the most common cancer in woman, has also yielded substantially to adrenalectomy. A recent five-year evaluation of 52 consecutive patients with metastatic mammary cancer who underwent adrenalectomy disclosed that significant objective remissions of varying lengths of time occurred in 20 patients. Prolonged survival-from three years to 68 months-occurred in seven of

these patients, all of whom had been suffering from advanced stages of the disease, had failed to respond to various other types of therapy and were incapacitated. After treatment, "all of them were able to resume their normal physical activities." One of the seven had had such extensive metastases that she "appeared to be moribund." but she survived, with great regression of the neoplasm, more than five years after adrenalectomy.

The pituitary gland, as well as the adrenal glands, has had an increasing apparent role in the control of breast cancer. Since 1951, the availability of ACTH and cortisone has allowed an intensive investigation of the effects of hypophysectomy, i.e., surgical removal of the pituitary body. The results have been most gratifying. A recent report, for

example, discloses that of twenty-eight patients with advanced breast cancer who underwent total hypophysectomy, "eighteen...have demonstrated striking objective clinical regressions" up to 20 months while an additional four who showed no objective evidence of regression experienced "striking relief of pain."

The dynamic state of current cancer research would appear to be demonstrated by the indication, already, that in the treatment of advanced breast cancer adrenalectomy, itself still in the infant stages, may yield to hypophytsectomy.

True, many types of cancer still run their course virtually unhampered by man's arduous efforts to inhibit them. But the number of cancers coming under some control is ever increasing. With medicine attacking on so many fronts with

so may weapons who would bet a man's life on when and how the next type of cancer will yield, if only just a bit?

True, we are not betting much of a life. For even in those areas where gains have been registered, the life is not "saved," death is only postponed. Of course, in a sense this is the case with every "cure" for every ailment. But it may be urged that after all there is a great deal of difference between the typical "cure" which achieves an indefinite postponement, more or less, and the cancer respite which results in only a brief intermission, so to speak, of rarely more than six months or a year. Is this really long enough to warrant all the bother?

Well, how long is long enough? In many recent cases of cancer respite, the patient, though experiencing only

temporary relief, underwent sufficient improvement to retake his place in society. Six or twelve or eighteen months is long enough to do most of the things which socially justify our existence, is it not? Long enough for a nurse to care for more patients, a teacher to impart learning to more classes, a judge to write a great opinion, a novelist to write a stimulating book, a scientist to make an important discovery and, after all, for a factory hand to put the wheels on an other year's Cadillacs.

CONCLUSION

The lower court decision should be affirmed.

DATED: 9/29/89

ROBERT L SASSONE,

Attorney for Amicus Curiae

NO 88-1503

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L AND JOYCE CRUZAN
Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,

v.

THAD C. McCANSE, GUARDIAN AD LITEM,
Respondent.

Affidavit of mailing of amicus brief copies, Rule 28.2

State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:

Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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Subscribed and sworn to before me on
October 11, 1989,

Lawrence D Sassone, Notary Public